MEDICAL RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

I authorize VEINatlanta to release my medical records to the following:

_____	_____
(REFERRING PHYSICIAN NAME)	(PRIMARY CARE PHYSICIAN NAME)
_____	_____
_____	_____
(Address) (Telephone Number)	(Address) (Telephone number)

I give _____ consent to release my
(Doctor or Practice Name)

Medical records to: VEINatlanta

1100 Johnson Ferry Road Center Pointe Bldg. 2 Suite 165 Atlanta, GA 30342

Phone: 404-446-2800 Fax: 404-446-2809

I understand the provision of healthcare treatment is not dependent on this authorization and I am not required to sign this authorization; however the information will not be disclosed without it. I understand that if anyone who receives my health information is not a health care provider or a health plan, federal privacy laws may no longer protect that health information.

I understand this authorization will include all medical records, including but not limited to: office notes, face sheets, history and physical, consultation notes, progress notes, treatment plans, correspondence and photographs.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand I have the right to revoke this authorization in writing at any time, except to the extent information has already been released pursuant to this authorization at the time of revocation. I can revoke this authorization by sending correspondence to the Manager of facility listed above.

This authorization shall expire one year after it is signed. A photocopy is as valid as the original.

_____ _____

(Date) (Patient Signature)